

# State of Connecticut Nursing Facility Payment Modernization Project: Case Mix Phase-In Methodology

September 2021



**MYERS AND  
STAUFFER**<sub>LC</sub>  
CERTIFIED PUBLIC ACCOUNTANTS

# AGENDA

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- Project Overview
- Rate Methodology Overview
- Rate Phase-In
- Value Based Purchasing
- Other Implementation Items
- Q&A

# ACRONYMS

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- **CMI** - Case-Mix Index; a weight assigned to a specific Resource Utilization Group or an average for a given population that reflects the relative resources predicted to provide care to a resident. The higher the case mix weight, the greater the resource requirements for the resident.
- **MDS** - Minimum Data Set; a core set of screening, clinical and functional elements, including common definitions and coding categories, which form the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare and/or Medicaid.
- **RUG-IV** - Resource Utilization Group, Versions IV; A category-based resident classification system used to classify nursing facility residents into groups based on their characteristics and clinical needs.
- **VBP** - Value Based Purchasing; payment methodology that links provider payments to improved performance by health care providers. Performance measures are defined in the methodology, and utilized in the reimbursement calculations.
- **FRV** - Fair Rental Value; the fair market value of property while rented out in a lease arrangement.

The background is a teal-tinted collage of financial and technical imagery. It includes a calendar with dates from 2011 to 2012, a stack of coins, a single coin, a ruler, a calculator, and a technical drawing of a mechanical part. The text 'Project Overview' is centered in white.

# Project Overview

# NF PAYMENT MODERNIZATION GOALS & OBJECTIVES

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- To reflect the Department's overall interest and work in modernizing rates.
- Establish a framework to align with value-based payment in the future.
- Align direct care reimbursement with the anticipated resource needs of each provider based on the acuity of their specific residents.
- Provide incentive for nursing homes to admit and provide care to persons in need of comparatively greater care.



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# RATE METHODOLOGY

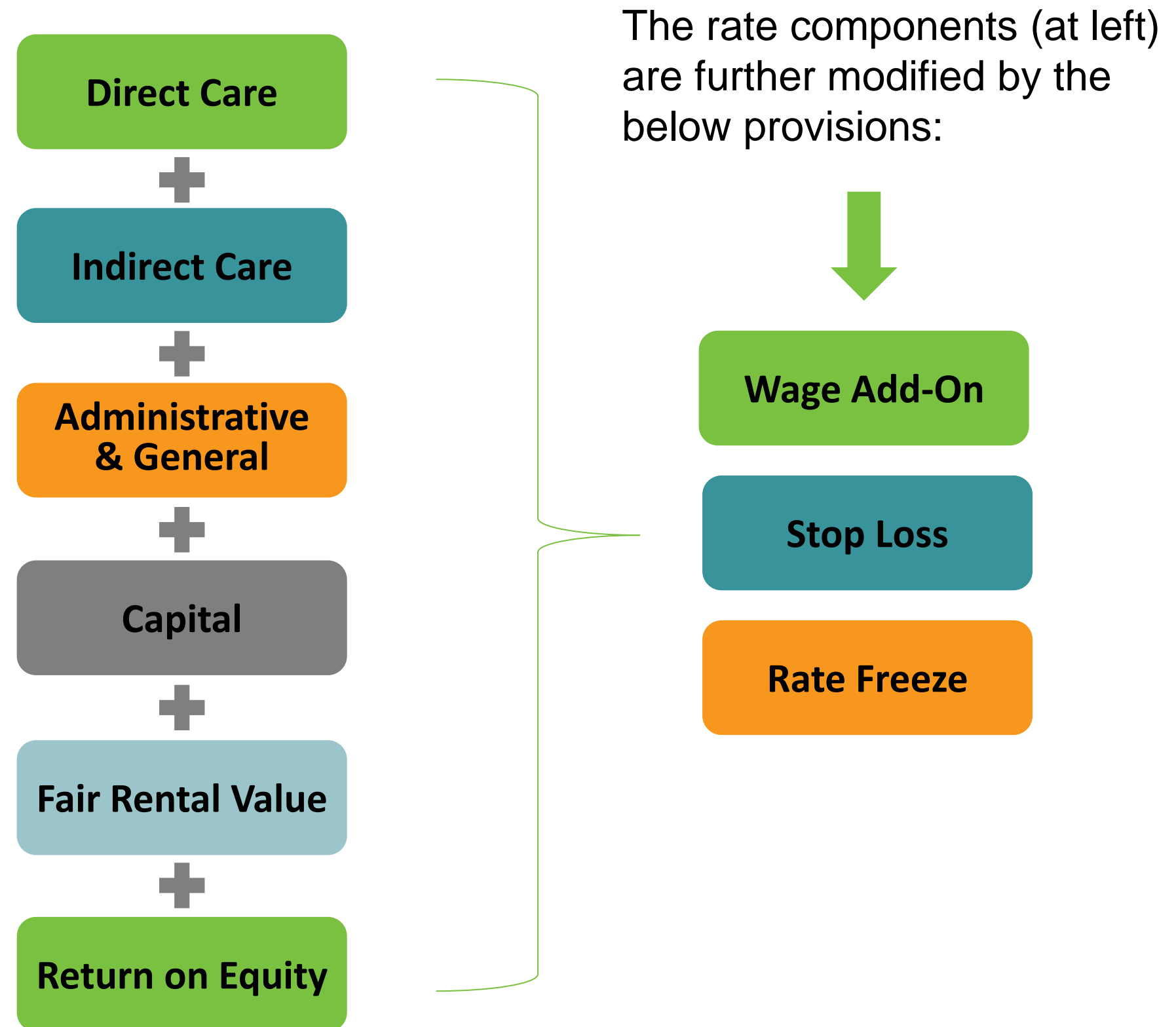
## OVERVIEW

# SYSTEM PARAMETERS

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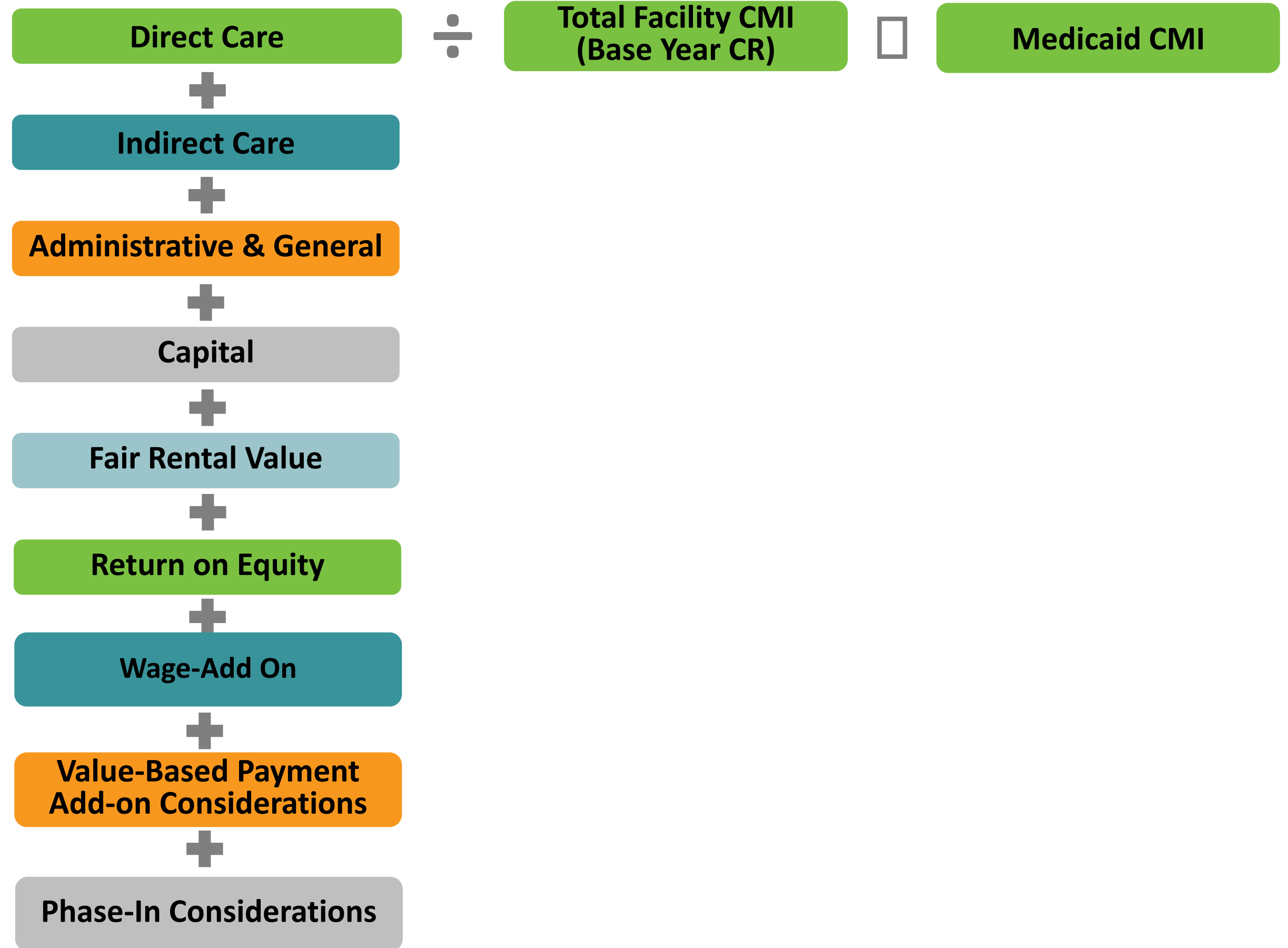
- **Case Mix System Implementation Date:** July 1, 2022
- **Methodology:** Rates to be calculated in accordance with Connecticut Regulations 17-311-52 and 17b-340.
  - Include acuity (case mix) into the direct care component
  - A single facility rate for both CCNH and RHNS beds will be determined
  - Vent and AIDS units/facilities will continue to receive a separate reimbursement rate.
  - No change in component cost classifications proposed
- **Base Year Cost Period:** 2019 cost reports will be utilized as basis for rate system

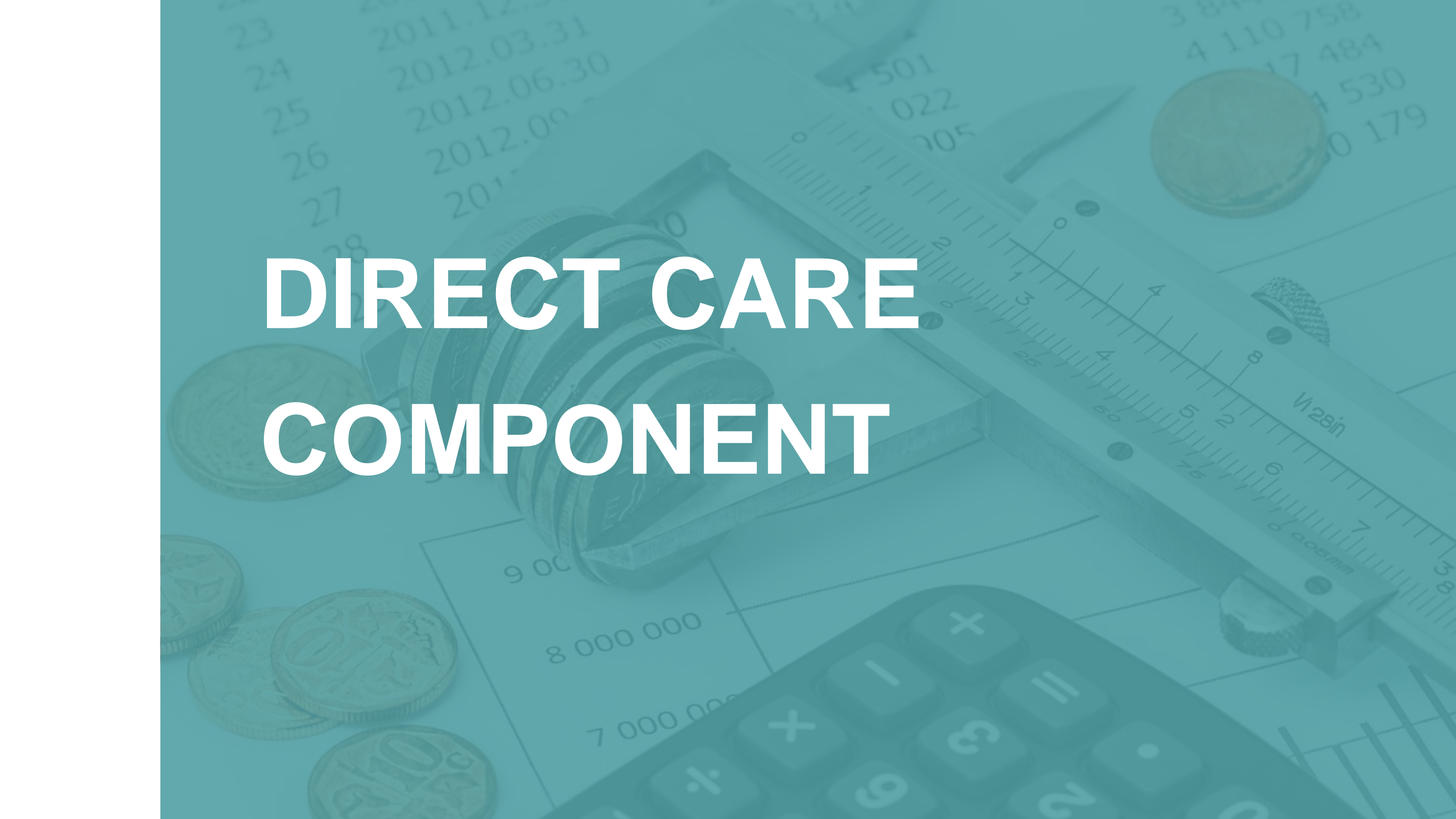
# CURRENT RATE METHODOLOGY





# CASE MIX METHODOLOGY



The background is a teal-tinted collage of financial and measurement-related items. It includes several coins (some showing '10' and '20'), a calculator with visible buttons like '+', '-', '=', and numbers, a ruler with markings, and a document with dates (2011.12.31, 2012.03.31, 2012.06.30, 2012.09.30) and numbers (23, 24, 25, 26, 27, 28).

# DIRECT CARE COMPONENT

# DIRECT CARE PARAMETERS

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- **Peer Groups:**
  - Fairfield County
  - Non-Fairfield Counties
- **Cost Component Limit:** 135% of Median
- **Minimum Occupancy Percentage:** 90%
- **Efficiency Percentage:** None

# STEP 1: DETERMINE DAYS DIVISOR

- Days are the greater of actual resident days or 90% of Bed Days Available

|  |        |
|--|--------|
| Beds   | 60     |
| Bed Days Available<br>(Beds X Days in CR Period)     | 21,900 |
| Minimum Occupancy %                                  | 90%    |
| Days @ Min. Occupancy                                | 19,710 |
| Total Days from CR                                   | 17,500 |
| Greater of Total CR Days or Days @<br>Min. Occupancy | 19,710 |



# STEP 2: DETERMINE NORMALIZING CMI

- Normalizing CMI is total all-payer CMI
- MDS assessments periods are matched to the corresponding cost reporting period, and a total days-weighted Normalizing CMI is calculated:

| MDS Assessment Period | CMI Points (RUG Weights X Days) | Days   |
|-----------------------|---------------------------------|--------|
| 10/1/18 – 12/31/18    | 4,400                           | 4,250  |
| 1/1/19 – 3/31/19      | 4,700                           | 4,500  |
| 4/1/19 – 6/30/19      | 4,900                           | 4,750  |
| 7/1/19 – 9/30/19      | 4,100                           | 4,000  |
| Totals for CR Period  | 18,100                          | 17,500 |
| Normalized CMI        | 1.0343                          |        |

- Providers reviewed 2 of 4 historical CMI periods
- For non-reviewed periods, the impact of delinquent records was removed

# STEP 3: CALCULATE NORMALIZED DC COST PER DAY

- Normalizing DC cost removes the effect of acuity on cost, and creates a uniform cost structure for Median calculations:

|  |              |
|--|--------------|
| Total DC Cost  | \$ 2,650,000 |
| Greater of Total CR Days or Days<br>@ Min. Occupancy | 19,710       |
| Total DC Cost Per Day                                | \$ 134.45    |
| Normalizing CMI                                      | 1.0343       |
| Total Normalized DC Cost Per Day                     | \$ 129.99    |

# STEP 4: CALCULATE MEDIANS

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- Normalizing DC cost per day for each provider is included in the median data sets
- Each peer group (Fairfield/Non-Fairfield) has the corresponding providers segregated and included only in calculating that specific median.
- From the median data sets, the arithmetic median is calculated.
- Fairfield County Median: \$141.15
- Non-Fairfield County Median: \$126.90

# STEP 5: CALCULATE DC COST LIMIT

- Peer group medians are multiplied by the cost component limit percentage

|               | Fairfield |        | Non-Fairfield |        |
|---------------|-----------|--------|---------------|--------|
| Median Value  | \$        | 141.15 | \$            | 126.90 |
| Cost Limit %  |           | 135%   |               | 135%   |
| DC Cost Limit | \$        | 190.55 | \$            | 171.32 |



# STEP 6: CALCULATE FACILITY ALLOWABLE DC COST PER DAY

- Normalized facility cost is compared against the DC cost limit
- The lesser of the DC cost limit, or the facility’s normalized DC cost is utilized as the allowable facility DC cost value

|                                  |                 |
|----------------------------------|-----------------|
| Facility Normalized DC Cost      | \$129.99        |
| DC Cost Limit (Non-Fairfield)    | \$171.32        |
| Lesser of Facility Cost or Limit | <u>\$129.99</u> |

# STEP 7: DETERMINE STATEWIDE CASE MIX NEUTRALITY FACTOR

- To ensure system growth stays within budgetary appropriations during each state fiscal year, a Statewide Case Mix Neutrality Factor will be calculated and applied quarterly as appropriate.
- This case mix neutrality factor will only be applied when the statewide Medicaid CMI exceeds the allowable state fiscal year growth threshold.

|                                      |               |
|--------------------------------------|---------------|
| Base Statewide Medicaid CMI Value    | 0.9612        |
| SFY CMI Allowed Growth Factor        | 0.75%         |
| Max SFY Statewide Medicaid CMI Value | <u>0.9684</u> |

|  |        |
|--|--------|
| Rate Period Statewide Medicaid CMI Value | 0.9712 |
| Statewide Medicaid CMI Neutrality Factor | 99.71% |

# STEP 8: CALCULATE MEDICAID CMI

- Reported Medicaid CMI values will be adjusted by any required quarterly Case Mix Neutrality Factor to determine the rate period Medicaid CMI Value.

|  |                     |
|--|---------------------|
| Reported Quarterly Medicaid CMI          | 1.018               |
| Statewide Medicaid CMI Neutrality Factor | <u>99.71%</u>       |
| Medicaid CMI for Rate Period             | <u><u>1.015</u></u> |

# STEP 9: CALCULATE MEDICAID ALLOWABLE DC COST PER DAY

- The allowable DC cost per day is multiplied by the facility’s rate period Medicaid CMI to arrive at the Medicaid allowable DC cost per day
- Medicaid CMI and thereby reimbursement rates are to be updated on a quarterly basis

|                                 |                  |
|---------------------------------|------------------|
| Allowable Facility DC Cost      | \$ 129.99        |
| Medicaid CMI                    | 1.015            |
| Total Medicaid DC CMI Adj. Cost | <u>\$ 131.94</u> |



# QUARTERLY CMI CYCLE

- The CMI calculation for each rate effective date period would correspond to active MDS assessment records as noted in the below table:

| MDS Assessment Period | Corresponding Rate Period |
|-----------------------|---------------------------|
| 1/1 - 3/31            | 7/1 - 9/30                |
| 4/1 - 6/30            | 10/1 - 12/31              |
| 7/1 - 9/30            | 1/1 - 3/31                |
| 10/1 - 12/31          | 4/1 - 6/30                |

The background is a teal-tinted collage. It includes a calendar with dates from 2011 to 2012, a stack of coins, a stack of paper bills, a medical syringe, a calculator, and a ruler. The text 'INDIRECT CARE COMPONENT' is overlaid in white, bold, sans-serif font.

# INDIRECT CARE COMPONENT

# INDIRECT CARE PARAMETERS

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- **Cost Component Limit:** 115% of Median
- **Minimum Occupancy Percentage:** 90%
- **Threshold for Efficiency Payment as Percentage of Median:** 100%
- **Allowed Efficiency Percentage:** 25%



The background is a teal-tinted collage of financial-related items. It includes a document with dates like '2011.12.31', '2012.03.31', and '2012.06.30'. There are several coins, including a large one in the top right and a stack of smaller ones in the bottom left. A calculator is visible in the bottom right corner, and a ruler is positioned diagonally across the middle. The text 'ADMINISTRATIVE & GENERAL COMPONENT' is overlaid in the center in a large, white, bold, sans-serif font.

# ADMINISTRATIVE & GENERAL COMPONENT



# A&G PARAMETERS

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- **Cost Component Limit:** 100% of Median
- **Minimum Occupancy Percentage:** 90%
- **Threshold for Efficiency Payment as Percentage of Median:** 100%
- **Allowed Efficiency Percentage:** 25%

# CAPTIAL COMPONENT

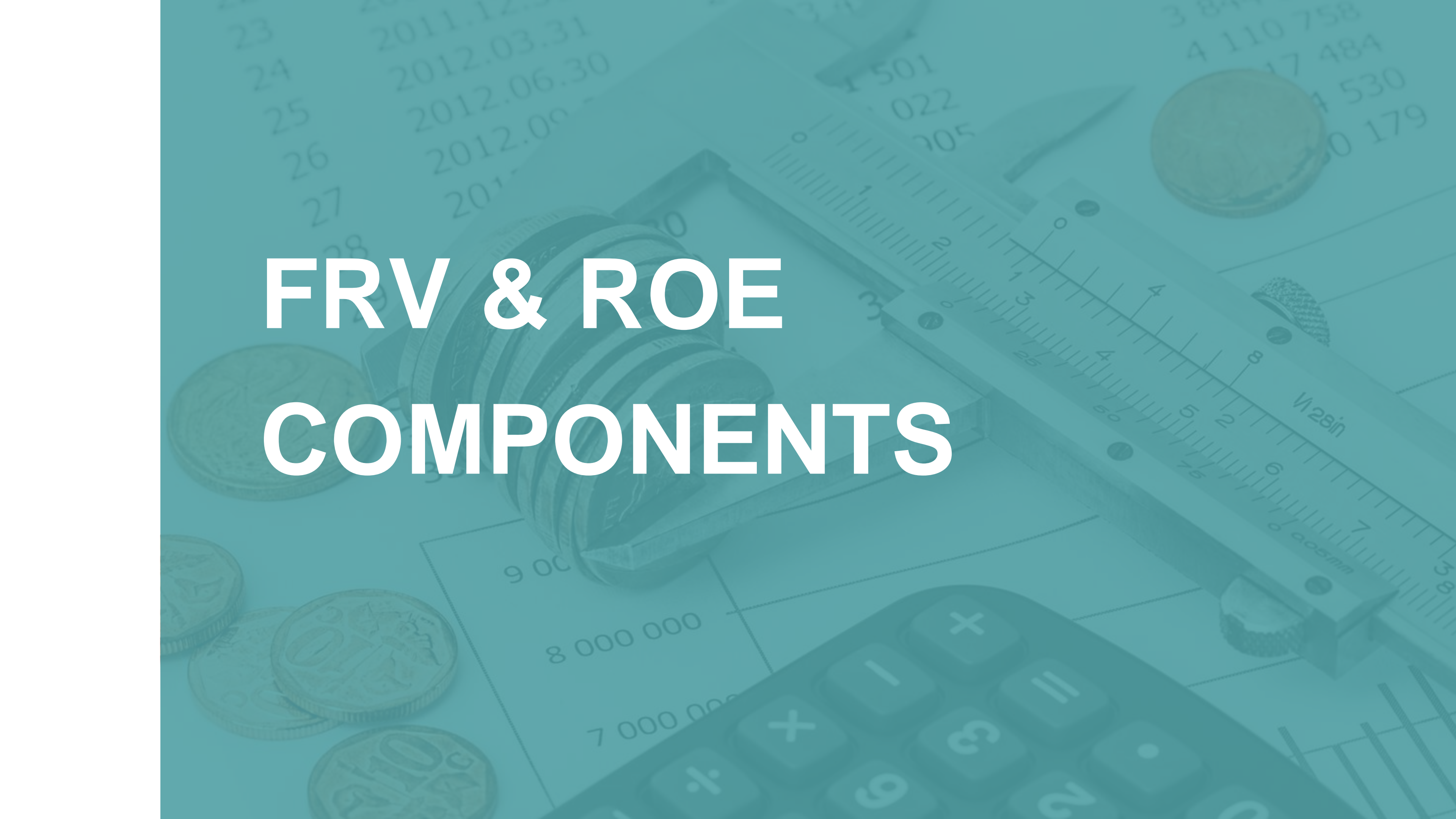
The background of the slide is a teal-colored collage of financial and mathematical imagery. It includes a stack of coins, several individual coins, a portion of a calculator showing buttons like '+', '-', '=', and numbers, and a ruler with various measurements. Faintly visible in the upper left are dates: 2011.12.31, 2012.03.31, 2012.06.30, and 2012.09.30. The overall theme is finance and accounting.

# CAPITAL PARAMETERS

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- **Cost Component Limit:** None
- **Minimum Occupancy Percentage:** 90%
- **Threshold for Efficiency Payment as Percentage of Median:** None
- **Allowed Efficiency Percentage:** None



The background of the slide is a teal-colored overlay on a collage of financial-related images. It includes several coins (some showing '10' and '20' denominations), a calculator with visible buttons like '+', '-', '=', and numbers, a ruler with markings, and a document with dates (2011.12.31, 2012.03.31, 2012.06.30, 2012.09.30) and numbers (23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100).

# FRV & ROE COMPONENTS

# FAIR RENT & ROE OVERVIEW

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- A fair rental value allowance is calculated to yield a constant amount each year in lieu of interest and depreciation costs. The allowance for the use of real property other than land is determined by amortizing the base value of property over its useful life.
- The useful life assigned to fair rental additions is based on the American Hospital Association guidelines.
- The rate of return applied to fair rent additions is based on the Medicare Rate of Return.
- Non-profit facilities receive the lower of the fair rental value allowance or actual interest and depreciation plus certain disallowed costs



The background of the slide is a teal-colored overlay on a collage of financial-related images. It includes several coins (some showing '10' and '20' denominations), a calculator with visible buttons like '+', '-', '=', and '3', a ruler with markings in inches and centimeters, and a document with dates (2011.12.31, 2012.03.31, 2012.06.30, 2012.09.30) and numbers (9 000 000, 8 000 000, 7 000 000).

# OTHER RATE COMPONENTS



# OTHER RATE COMPONENTS

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- Legislative Wage Add-Ons

# RATE PHASE-IN

The background of the image is a teal-colored overlay on a collage of financial-related items. It includes several coins (some showing '10' and '20'), a stack of coins, a calculator with visible buttons like '+', '-', '=', and numbers, and a ruler with markings. There are also some faint numbers and dates visible in the background, such as '2011.12.31', '2012.03.31', '2012.06.30', and '2012.09.30'.

# PHASE-IN OVERVIEW

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- DSS is implementing a phase-in of rebase impact over a 3 year period (SFY 2023 – SFY 2025)
- Phase-In is a process that grants additional provider financial certainty for a limited period of time
- This limited time period allows for providers to evaluate the impact of the new reimbursement system on their operations and modify as necessary.

# PHASE-IN PARAMETERS

| Selected Parameters       | SFY 2023 | SFY 2024 | SFY 2025 |
|---------------------------|----------|----------|----------|
| Cost report year          | 2019     | 2019     | 2019     |
| Case mix neutrality limit | 0.75%    | 1.51%    | 2.27%    |
| Stop gain                 | \$6.50   | \$20     | None     |
| Stop loss                 | \$0      | \$5      | None     |

# PHASE-IN EXAMPLE # 1

| Facility W/ Case Mix Rate GREATER Than Issued Rate |          |         |          |         |           |
|--|----------|---------|----------|---------|-----------|
|  | SFY 2023 |         | SFY 2024 |         | SFY 2025  |
| Case Mix Rate                                      | \$       | 280.00  | \$       | 280.00  | \$ 280.00 |
| Issued Rate  | \$       | 245.00  | \$       | 245.00  | \$ 245.00 |
| Initial Gain/(Loss)                                | \$       | 35.00   | \$       | 35.00   | \$ 35.00  |
| Phase-In Adjustment                                | \$       | (28.50) | \$       | (15.00) | None      |
| Total Case Mix Rate After Phase-In                 | \$       | 251.50  | \$       | 265.00  | \$ 280.00 |
| Gain/(Loss) After Phase-In                         | \$       | 6.50    | \$       | 20.00   | \$ 35.00  |



# PHASE-IN EXAMPLE # 2

| Facility W/ Case Mix Rate LESS Than Issued Rate |          |         |          |         |            |
|---|----------|---------|----------|---------|------------|
|   | SFY 2023 |         | SFY 2024 |         | SFY 2025   |
| Case Mix Rate                                   | \$       | 235.00  | \$       | 235.00  | \$ 235.00  |
| Issued Rate                                     | \$       | 245.00  | \$       | 245.00  | \$ 245.00  |
| Initial Gain/(Loss)                             | \$       | (10.00) | \$       | (10.00) | \$ (10.00) |
| Phase-In Adjustment                             | \$       | 10.00   | \$       | 5.00    | None       |
| Total Case Mix Rate After Phase-In              | \$       | 245.00  | \$       | 240.00  | \$ 235.00  |
| Gain/(Loss) After Phase-In                      | \$       | -       | \$       | (5.00)  | \$ (10.00) |

The background is a teal-tinted collage of financial and measurement-related items. In the top left, a table lists dates from 2011 to 2012. A stack of coins is in the center, with a single coin on top. A calculator is in the bottom right, and a ruler is positioned diagonally across the middle. 

# VALUE BASED PURCHASING

# VBP INCORPORATION

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- VBP program will be “Reporting Only” for initial implementation
- For the period after initial reporting-only phase (year 2 and beyond), DSS will propose further modifications to the payment strategy involving performance on quality metrics
- Stakeholder workgroups have been established to work toward selecting initial metrics and implementation strategy
- Additional quality metrics will be evaluated for implementation throughout all phases of the modernization project



The background is a teal-tinted collage of financial and measurement-related items. It includes a stack of coins, a ruler, a calculator, and a document with dates and numbers. The text 'OTHER IMPLEMENTATION ITEMS' is overlaid in white, bold, sans-serif font.

# OTHER IMPLEMENTATION ITEMS

# SHADOW RATES

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- Shadow Rates will be issued to all Medicaid providers on or before October 1, 2021
- Shadow Rates will communicate the impact of the case mix reimbursement system to each individual provider
  - The impact of the phase-in process will be incorporated and displayed
- Shadow Rates will be distributed to providers on a quarterly basis until the implementation of the case mix system



# SHADOW RATES CAVEATS AND ASSUMPTIONS

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- Shadow Rates will be based on the most currently available Case Mix Index and Cost Report Information
- Case Mix Index information will continue to be updated on a quarterly basis in line with the preliminary and final resident roster process
- Shadow Rates are for illustrative purposes only, and will not be utilized for reimbursement purposes
- Base cost assumptions in Shadow Rates are subject to additional review/audit adjustment as those processes are completed
- Rates may continue to be adjusted for other factors such as additional wage add-ons or other factors prior to system implementation



# QUESTIONS?